Consent to Share Medical Information

Nominated Third Party Organisation

This form authorises Dokotela to share your medical information with the nominated Third-Party Organisation and permits representatives from the nominated Third Party to communicate and act on your behalf in relation to your care. Your consent is voluntary and may be withdrawn at any time in writing.

Part A — Patient Details

Full Name:	
Date of Birth:	/ /
Address:	
Phone Number:	
Email Address:	

Part B — Nominated Third Party Details

I authorise the following organisation to communicate with Dokotela on my behalf and to receive information about my care.

Organisation:	
Company Address:	
Phone Number:	
Email Address:	
Current Representative Name:	
Representative Role:	

Part C — Patient Acknowledgement & Signature

By signing below, I acknowledge and confirm that:

- ☐ I have read and understood this form and the purpose for which my information will be used and shared.

- ☐ Dokotela may speak with and share my medical information with any representative from the nominated organisation.
- ☐ I provide this consent voluntarily and understand I may withdraw it at any time by notifying the clinic in writing.
- ☐ I understand my information will be handled in accordance with the Privacy Act 1988 (Cth) and Dokotela's Privacy Policy (dokotela.com.au/privacy-policy).

_____ **Patient Signature**	_____ **Date**

_____ **Print Patient Name**

If signed by a Guardian, Carer, or Legal Representative

Complete this section if applicable.

Name of Representative:	
Relationship to Patient:	
Authority (e.g. POA, Guardian):	

_____ **Representative Signature**	_____ **Date**